STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495358	A. BUILDING _____ B. WING _____	C 03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMELIA NURSING CENTER	8830 VIRGINIA STREET AMELIA, VA 23002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 3/8/16 through 3/10/16. Corrections are required for compliance with the following Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 100 certified bed facility was 88 at the time of the survey. The survey sample consisted of 16 current resident reviews (Residents # 1 through # 15 and # 21) and six closed record reviews (Residents # 16 through # 20 and #22).	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information	F 164	1. LPN #11 was given 1:1 instruction regarding privacy during medication administration. This to include asking the residents what their preferences are for where and how they prefer to accept their medications. 03/31/2016 2. Medication pass with all nurses by DON, ADON, and QA nurse to assure that the nurses follow the guidelines for privacy and preferences. In-service with all licensed nursing staff regarding resident privacy and preferences during medication pass. 03/31/2016	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Virginia M. Snead	Administrator	3-31-16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
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F 164	Continued From page 1 contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review it was determined that facility staff failed to maintain personal privacy for two of 22 residents in the survey sample; Residents #8 and #13. 1) Facility staff failed to maintain personal privacy while administering eye drops to Resident #8. 2) Facility staff failed to maintain personal privacy while administering an insulin injection to Resident #13. The findings include: 1. Resident #8 was admitted to the facility on 6/23/14 with diagnoses that included but were not limited to dementia with Lewy bodies*, muscle weakness, Parkinson's disease, stroke, and dry eye syndrome. Resident #8's most recent MDS (Minimum Data Set) assessment was a quarterly review assessment with an ARD (Assessment Reference Date) of 12/24/15. Resident #8 was coded as being severely cognitively impaired in the ability to make daily life decisions scoring two out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #8 was coded as sometimes being understood and sometimes	F 164	3. Medication pass to be conducted monthly by QA nurse on all shifts to assure nurses are following guidelines for privacy and preferences. 4. QA nurse to report results to the QA committee quarterly.	03/31/2016 04/20/2016

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F 164	Continued From page 2	F 164		

understanding others for communication. Resident #8 was coded as being totally dependent on staff with transfers and locomotion on and off the unit and bathing. Resident #8 was coded as requiring extensive assistance from staff with dressing, toileting, and personal hygiene.

On 3/9/16 at 3:45 p.m., Resident #8 was observed sitting in the hallway in front of LPN (licensed practical nurse) #11's medication cart. At 3:46 p.m., LPN #11 was observed administering one eye drop into each eye of Resident #8 in the hallway. LPN #11 did not take Resident #8 somewhere private to administer the eye drops or ask the resident's permission to administer the eye drops in public.

Review of Resident #8's clinical record revealed the EMAR (electronic medication record) that documented the following order, "Refresh Tears drops** 0.5%; Amount to administer: 1 drop; ophthalmic (by eye)..Apply one drop in each eye four times a day FOR DRY EYES...at 8:00a.m., 12:00 a.m., 4:00 p.m., and 8:00 p.m."

On 3/10/16 at 11:00 a.m., an interview was conducted with LPN #3, regarding ensuring resident privacy when administering medications. LPN #3 stated that she would take the resident into their room for medications like injections or topical creams. LPN #3 stated that she would shut the door and pull the curtain for additional privacy. When asked about administering eye drops she stated that she would first ask the resident's permission before administering in public or she would take the resident back to their room. When asked about residents who are cognitively impaired, she stated, "The same rules

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F 164	Continued From page 3	F 164		

apply for these residents."

On 3/10/16 at 11:10 a.m., an interview was conducted with RN (registered nurse) #1, the unit manager, regarding ensuring resident privacy when administering medication. RN #1 stated that preferably nurses should administer medications in their (resident's) room. RN #1 stated that the sometimes the resident is not in their room and should be asked permission prior to administering medications in public. When asked if Resident #8 can make his own decisions about where he would like to receive his medications, RN #1 stated, "No. He can't make many decisions at all." When asked how he should receive his medications RN #1 stated, "He should be brought to his room to give him more privacy."

LPN #11 was not available for an interview.

On 3/10/16 at approximately 2 p.m., administration was made aware of the above concerns. No further information was presented during survey.

Facility policy titled, "Protocol for Medication Administration" documents in part, the following: "...2. In addition each resident must be allowed to decide where he/she wishes to receive his/her medication. 3. It is the responsibility of the charge nurse administering the medication to ask and respond appropriately to the resident's wishes. This must be done with each medication administration. 4. When administering any invasive medication (i.e. injections, IV medications, PEG tube medications, eye drops, inhalers, etc.), this must be done in a private area with privacy assured by pulling privacy curtain and shutting the door."

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*Dementia with Lewy Bodies- "is one of the most common types of progressive dementia. The central features of DLB include progressive cognitive decline, "fluctuations" in alertness and attention, visual hallucinations, and parkinsonian motor symptoms, such as slowness of movement, difficulty walking, or rigidity. People may also suffer from depression." This information was obtained from http://www.ninds.nih.gov/disorders/dementiawithlewybodies/dementiawithlewybodies.htm
**Refresh Tears-Artificial tears-"Keep eyes moist with isotonic solutions and wetting agents in the management of dry eyes due to lack of tears..." This information was obtained from Davis's Drug Guide for Nurses, 11th edition p.1351.

2. Resident #13 was admitted to the facility on 12/19/2011 and readmitted on 4/24/14 with diagnoses that included but were not limited to Alzheimer's disease, high blood pressure, type two diabetes and hypothyroidism.

Resident #13's most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 2/2/16. Resident #13 was coded as being severely cognitively impaired in the ability to make daily life decisions scoring 99 on the BIMS (Brief Interview for Mental Status) exam. Resident #13 was coded as usually understanding others and being understood by others for communication. Resident #13 was coded as requiring extensive assistance from staff with transfers, dressing, toileting, and personal hygiene.

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On 3/9/16 at 3:35 p.m., Resident #13 was observed sitting in the day room watching television with other residents. LPN #11 was then observed walking up to Resident #13 with an insulin syringe in her hand. LPN #11 told Resident #13 that she needed a shot and then she (LPN #11) lifted up Resident #13's shirt, exposing her abdomen and administered the insulin injection. LPN #11 did not take Resident #13 somewhere private to administer the insulin injection or ask the resident's permission to administer the medication in public.

Review of Resident #13's most recently signed POS (physician order sheet) dated 1/18/16 revealed an order that documented the following, "Novolog*** (insulin aspart) solution; 100 unit/ml; subcutaneous; Special Instructions: INJECT 3 UNITS SQ (subcutaneous-beneath, under all layers of the skin) 3 TIMES A DAY WITH MEALS; 08:00 A.M, 12:00 P.M., 05:00 P.M."

On 3/10/16 at 11:00 a.m., an interview was conducted with LPN #3, regarding ensuring resident privacy when administering medications. LPN #3 stated that she would take the resident into their room for medications like injections or topical creams. LPN #3 stated that she would shut the door and pull the curtain for additional privacy. LPN #3 stated that nurses should try not to expose any private areas of the skin to other people including the abdomen. When asked about residents who are cognitively impaired, she stated, "The same rules apply for these residents."

On 3/10/16 at 11:10 a.m., an interview was conducted with RN (registered nurse) #1, the unit manager, regarding ensuring resident privacy

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F 164	Continued From page 6 when administering medication. RN #1 stated that preferably nurses should administer medications in their (resident's) room. RN #1 stated that the sometimes the resident is not in their room and should be asked permission prior to administering medications in public. When asked if Resident #13 can make her own decisions about where she would like to receive medications, RN #1 stated, "Her dementia has increased, no she cannot make her own decisions." RN #1 also stated that injections in the abdomen should always be given in private. LPN #11 could not be reached for an interview. On 3/10/16 at approximately 2 p.m., administration was made aware of the above concerns. No further information was presented during survey. ***Novolog Insulin Aspart- "Used for the control of hyperglycemia (high blood sugar levels) in patients with type 1 or type 2 diabetes." This information was obtained from Davis's Drug Guide for Nurses, 11th edition p. 670.	F 164		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a	F 225	1. The DON who failed to send the report in a timely manner has retired. 2. The on-call RN's have been in-serviced regarding the procedure for reporting incidents of unknown origin to the state and initiation of the investigation in a timely manner per the abuse policy.	12/10/2015 03/18/2016

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F 225	Continued From page 7	F 225	3. Nursing staff has received in-service regarding the abuse policy and the necessity of calling the DON or on-call RN as soon as an incident of unknown origin is discovered.	03/31/2016
			4. QA nurse to review facility reports monthly and report to QA committee quarterly.	03/31/2016

court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review and facility document review it was determined that facility staff failed to immediately report an injury of unknown origin to the required state agency and other officials in accordance with State law through established procedures.

The facility staff reported an injury of unknown

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origin that occurred on 6/20/15 to the required state agency on 6/23/15 for Resident #22 (exceeding 24 hours).

The findings include:

Resident #22 was admitted to the facility on 5/25/13 with diagnoses that included but were not limited to COPD (chronic obstructive pulmonary disease), great toe amputation, osteoporosis, high blood pressure, and paroxysmal tachycardia.

Resident #22's most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 7/6/2015. Resident #22 was coded as being severely cognitively impaired in the ability to make daily decisions scoring 99 on the BIMS (Brief Interview for Mental Status). Resident #22 was coded as requiring extensive assistance from staff with dressing, eating, and bed mobility; and total dependence on staff with toileting, personal hygiene and bathing. Resident #22 was coded as receiving hospice services. Resident #22 expired on 8/9/15.

Review of the facility FRIs (Facility Reported Incidents) revealed that Resident #22 had swelling to her left wrist on 6/19/15. The facility ordered an x-ray on 6/19/15 that documented the following: "Impression: 1. Old fracture deformity...degenerative changes and osteopenia." Further review of the clinical record revealed that the resident went out to the hospital per daughter request for a second opinion on 6/20/15.

Review of Resident #22's hospital discharge orders dated 6/20/15 revealed that Resident #22

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had a left wrist sprain. Further review of the hospital discharge summary revealed that Resident #22 was ordered to continue her left wrist splint for comfort. Review of the resident census records revealed that Resident #22 came back to the facility on 6/20/15 at 7:00 p.m.

Further review of the FRIS revealed that an internal investigation was imitated on 6/19/15 for the left wrist swelling. A confirmation fax revealed that the facility had reported this incident to the required state agency on 6/23/15 at 9:48 a.m., four days after the incident and three days after the injury was determined to be of unknown origin. The facility did not immediately report the incident within the 24 hour time frame.

On 3/10/16 at 11:45 a.m., an interview was conducted with ASM (administrative staff member) #1, the administrator, regarding reporting an injury of unknown origin. ASM #1 stated that if a resident presents with an injury of unknown origin than it must be reported to the state. She stated that the nurse who finds the injury would do an incident report and call the DON (Director of Nursing) or the on-call RN (registered nurse) to start an investigation. ASM #1 stated that the facility investigates and reports the incident within 24 hours to the state and then the facility has up to 5 days to send a final follow up report to the state. ASM #1 stated the reason why Resident #22's incident was not reported to the state in a timely manner is because when the incident first occurred, it was not declared an injury of unknown origin. She stated, "Our x-rays showed an old fracture and no injury. It was not until Saturday that she came back from the hospital with a sprain." When asked if the facility should have reported the sprain of unknown

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origin after it was discovered on 6/20/15 she stated, "I don't think there was anyone in the building on Saturday who knew how to report the incident. The DON at the time was not at work that Saturday and I think she finished up the report when she came back to work on Monday." When asked if the nurses can call the DON or on -call nurses to come in to help report an incident she stated, "I guess they could do that."

On 3/10/16 at approximately 12:00 p.m., an interview was conducted with RN #2, the previous DON who worked during the incident. She stated that she was not made aware of the resident going to the hospital on Saturday 6/20/15. She stated that she only had knowledge of Resident #22's negative x-ray on 6/19/15. RN #2 stated, "I reported the incident to the state when I arrived back to work on Monday and found out that she had visited the hospital." When RN #2 was informed the incident was not reported until Wednesday, the 23rd of June, she stated, "That's right. It was late because I wasn't sure if this was an incident that needed to be reported but then I felt it was better late than never."

At 11:45 a.m., administration was made aware of the above findings. No further information was presented prior to exit.

Facility policy titled, "Reporting Injuries of Unknown Origin documents, in part the following: "Injuries of unknown origin must be in the same regulatory light as mistreatment, neglect and abuse and must be reported if there is reasonable cause to believe or suspect that an injury has been inflicted upon a resident by a nurse aide or another individual used by the facility...If an injury of unknown origin requires

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F 225	Continued From page 11 physician intervention regardless of whether there is, or is not, reasonable cause to believe it was inflicted by a staff member, it should be reported to the Center for QHCS (quality health care services) and (initials of organization) and APS (adult protective services), and the Ombudsperson with appropriate follow-up...For purposes of reporting to above agencies, "immediately is defined as the same day of, or the next business day following, the occurrence of the alleged incident."	F 225		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by:	F 280	1. Resident #3 was evaluated by MD and an order was written for self-release seat belt. At this time a care plan was written for the use of the self release seat belt. 03/17/2016 2. Unit manager will audit monthly all residents charts in regarding to use of self-release belts. MDS will review all new orders for care plan updates daily. 03/25/2016 3. Protocol written for updating care plans and MDS coordinator and assistant have been educated. Unit managers report all new orders to MDS for care plan updates. 03/28/2016 4. MDS coordinator will report care plan updates being reviewed in a timely manner to the QA committee on a quarterly basis. 04/20/2016	

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Based on observation, staff interview, clinical record review and facility document review it was determined that facility staff failed to review and revise a comprehensive care plan for one of 22 residents in the survey sample; Resident #3.

Facility staff failed to update Resident #3's comprehensive care plan for a self-release seat belt used for safety.

The findings include:

Resident #3 was admitted to the facility on 3/13/14 and readmitted on 12/29/15 with diagnoses that included but were not limited to cerebral infarction (stroke), chronic kidney disease, dysphagia, and aphasia.

Resident #3's most recent MDS (minimum data set) was a 14 day scheduled assessment with an ARD (assessment reference date) of 1/12/16. Resident #3 was coded as being severely cognitively impaired in the ability to make daily decisions on the Staff Assessment for Mental Status. Resident #3 was coded as being totally dependent on staff for transfers, eating, toileting, personal hygiene and bathing.

On 3/9/16 at 3:30 p.m., Resident #3 was observed in the day room leaning forward wearing a seat belt. Review of Resident #3's clinical record revealed no evidence of a seat belt.

Review of Resident #3's care plan dated 12/3/15 did not address the use of a seat belt.

On 3/10/16 at 11:20 a.m., an interview was conducted with RN (registered nurse) #4 and RN

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AMELIA NURSING CENTER	8830 VIRGINIA STREET AMELIA, VA 23002

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#1, the unit manager. When asked why Resident #3 had a seat belt in place RN #4 stated, "That is used for safety because he likes to lean forward. He can release the seat belt himself." RN #1 stated that this seat belt was not a restraint. When asked when the seat belt was put in place RN #1 looked through the nurses notes and stated, "I am not sure, I can't find anything."

On 3/10/16 at 11:25 a.m., an interview was conducted with RN #3. She looked through therapy progress notes and stated, "I don't see anything about when a seat belt was applied."

On 3/10/16 at 11:35 a.m., RN #4 stated, "I just went down to the therapy and they said they were not responsible for applying a seat belt. I am not sure when this was put on." She stated that it must have been applied after a fall.

On 3/10/16 at approximately 11:55 p.m., Resident #3 was observed in the day room taking off his seatbelt during activities.

On 3/10/16 at approximately 12:15 p.m., further interview was conducted with RN #3. When asked the care plan process she stated that MDS was responsible for creating a care plan and updating the care plan when a new order is written. She stated that the unit managers will write the order and put a copy in the MDS box for the MDS nurses to update the care plan. When asked who updates interventions after a fall or change in condition that does not need an order she stated, "All disciplines get involved during care plan meetings. Changes are discussed during these meetings and MDS will update the care plan."

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On 3/10/16 at approximately 1:00 p.m., an interview was conducted with LPN (licensed practical nurse) #10, the MDS nurse. When asked about the care plan process she stated that MDS creates the interim care plan within 24 hours upon admission. She stated that within 14 days MDS will create a more in depth care plan based on triggered care areas. She stated that she will also create the care plan based on interviews with staff and observation of the resident. She stated that the care plan is updated anytime there is a new order for the resident. LPN #10 stated that she receives the order from the unit managers or from the matrix (computer) system. When asked how MDS updates the care plan after a change in condition such as a fall, she stated that she receives that information in risk management meetings or from the unit manager. When asked if she was aware that Resident #3 had a seat belt in place she stated, "No." When asked if this should have been on the care plan she stated, "Yes." LPN #10 stated that she uses the RAI (resident assessment instrument manual) as a reference when completing the care plans. A policy on updating care plans could not be provided.

On 3/10/16 at approximately 2:00 p.m., administration was made aware of the above findings. No further information was presented prior to exit.

According to Potter and Perry's, Fundamentals of Nursing, 7th Edition, page 269 states "A written care plan communicates nursing care priorities to other health care professionals. The nursing care plan enhances the continuity of care by listing specific nursing interventions needed to achieve the goals of care. The complete care plan is the

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F 280	Continued From page 15 blueprint for nursing action. It provides direction for implementation of the plan plus the framework for evaluation of the client's response to nursing actions."	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to follow professional standards of practice for one of 22 residents in the survey sample; Resident #18. For Resident #18, the facility staff failed to document on the MAR (Medication Administration Record) the administration of acetaminophen for pain relief. The findings include: Resident #18 was admitted on 10/24/15 and left the facility AMA (against medical advice) on 10/25/15. Resident #18 was admitted with diagnoses of but not limited to hernia repair, diabetes, fibromyalgia, and degenerative disc disease. A MDS (Minimum Data Set) had not yet been completed. According to nurse's notes and admission assessments dated 10/24/15, the resident was alert and oriented to person, place, and time; was independently ambulatory, was	F 281	1. Resident #18 is no longer a resident at the facility. Left against medical advice on 10/25/2015. 2. QA nurse will audit all EMAR charts on each unit for timely documentation of all medications as given . QA nurse will perform on a monthly basis. 3. All RN's and LPN's will be in-serviced on documentation of medication administration as per medication administration protocol with emphasis on prompt documentation after administration of medications 4. QA nurse will do a monthly review of EMARs and report to the QA committee quarterly.	03/31/2016 03/31/2016 04/20/2016

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independent in activities of daily living, and was continent of bowel and bladder.

During the investigation of a complaint allegation about the availability and administration of pain medication for Resident #18, a review of the clinical record revealed the following:

New admission medication orders which included:
*Lortab (used to relieve moderate to severe pain) 5-325 mg (milligrams) every 4 hours PRN (as needed) and STAT (immediately);
**meloxicam (used to relieve pain, tenderness, and swelling) 15 mg at bedtime and STAT;
***acetaminophen (used to relieve mild to moderate pain) 325 mg tablets, give 2 tablets every 4 hours PRN.

A review of the Pyxis**** (electronic medication distribution system) record revealed that on 10/24/15 at 7:28 p.m., the acetaminophen was pulled to administer to Resident #18. A review of the MAR failed to reveal the acetaminophen was administered. A review of the nurse's notes also failed to reveal the acetaminophen was administered.

On 3/10/16 at 1:41 p.m., in a phone interview with LPN #8 (Licensed Practical Nurse), who no longer worked at the facility, she stated that she, together along with (LPN #7) pulled meds (medications) for Resident #18, as LPN #8 was the only nurse in the facility at the time that had access to the Pyxis, and LPN #7 was the resident's nurse. She stated that once the meds were pulled, she did not administer them, that it was LPN #7 that administered them and should have signed out that the acetaminophen was

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given (as was done with other meds pulled at that time, administered, and signed out for on the MAR.)

Attempts were made to contact LPN #7, who no longer worked at the facility, on 3/10/16 at 10:23 a.m., 11:48 a.m., and 11:56 a.m. LPN #7 was unavailable for interview.

A review of the facility policy "Medication Administration" documented, "8. Every administration shall be recorded immediately on the resident's chart and initialed by the person administering it."

On 3/10/16 at 1:15 p.m., the Administrator and Director of Nursing (DON) were made aware of the concerns. At 4:00 p.m., the DON was asked what professional standards the facility follows. She stated she did not know. No further information was provided by the end of the survey.

According to Fundamentals of Nursing, Sixth edition, 2007; by Perry and Potter, page 843 reads "After the nurse administers the medication, the medication administration record (MAR) is completed per agency policy to verify that the medications was given as ordered."

*Information obtained from https://www.nlm.nih.gov/medlineplus/druginfo/meds/a601006.html

**Information obtained from https://www.nlm.nih.gov/medlineplus/druginfo/meds/a601242.html

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F 281	Continued From page 18 ***Information obtained from https://www.nlm.nih.gov/medlineplus/druginfo/meds/a681004.html ****The Pyxis MedStation® automated medication dispensing system supports decentralized medication management with various features for safety and efficiency. The system helps accurately dispense medication, while supporting pharmacy workflows. Information obtained from http://www.carefusion.com/our-products/medication-and-supply-management/medication-and-supply-management-technologies/pyxis-medication-technologies/pyxis-medstation-system	F 281		
F 309 SS=E	COMPLAINT DEFICIENCY 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to follow physician's orders for one of four residents in the Medication Administration observation; Resident #14.	F 309	1. 1:1 counseling with LPN #6 regarding medication administration and documentation of parameters prior to administration of medication. 2. 100% audit of all medications. Audit of all medications requiring parameters to assure documentation of parameters have been completed.	03/31/2016 03/31/2016

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F 309	Continued From page 19	F 309	3. In-service all RN's and LPN's regarding the administration of medications that have BP, pulse, or any physician required parameter prior to administration with emphasis on completion of task prior to administration of medications.	03/31/2016
			4. QA nurse to evaluate on a monthly basis EMARS and treatment sheets in regards to parameter documentation and report to QA committee quarterly.	04/20/2016

The facility staff administered lisinopril* (used to treat high blood pressure) to Resident #14 without checking the blood pressure in accordance with physician's orders, for the month of February 2016 and March 2016.

The findings include:

Resident #14 was admitted to the facility on 11/6/13 with the diagnoses of but not limited to dementia, blindness, enlarged prostate, dysphagia, and high blood pressure. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 2/15/16. The resident was coded as being cognitively impaired in ability to make daily life decisions. The resident required total care for bathing; extensive assistance for transfers, dressing, eating, and hygiene; and was incontinent of bowel and bladder.

A review of the clinical record revealed an order dated 6/27/14 for "lisinopril* (used to treat high blood pressure) 5 mg (milligrams) daily at 9:00 a.m., hold if the SBP (systolic blood pressure - the top number in a blood pressure reading) is less than 110."

On 3/9/16 at 8:46 a.m., the Medication Administration Observation task was conducted with LPN **#6** (Licensed Practical Nurse). She was observed to prepare and administer the following medications for Resident #14:
lisinopril 5 mg, 1 tab (tablet)
**sodium chloride (used for prevention of muscle cramps and heat prostration; restoration of sodium ion in hyponatremia) 1 gram tab, gave 2

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F 309	Continued From page 20 tabs ***Thera multivitamin 1 tab ****Vitamin B1 (replacement therapy) 100 mg, one tab. LPN #6 administered the lisinoprll 5 mg tab to Resident #14 without taking a blood pressure. On 3/10/16 at 2:16 p.m., a phone Interview was conducled with LPN #6. When asked about the blood pressure, she stated she took the blood pressure at about 7:50 a.m. (approximately 1 hour before administering the lisinopril). When asked where she documented this, she stated on lhe 24-hour report form. A review of the 24 hour report revealed that there were no notes of any sort, includlng vital signs, documented next to the name of Resident #14. A review of the clinical record for February 2016 and March 2016 failed to reveal any evidence of any blood pressures taken except for a monthly blood pressure on 2/1/16, which was 136/48, and was not taken in conjunction with the administration of the lisinoprll. Also a nurse's note documented on 3/7/16 a blood pressure of 130/70, which also was not in conjunction with the administration of the lislnopril. No other evidence of blood pressure could be located in the clinical record for February and March 2016. A review of the care plan for Resident #14 revealed one dated 2/16/16 for "Cardio; Dx (diagnoses) of HTN (high blood pressure)....Receives antihypertensives/cardiac meds daily." Interventlons included one dated 2/16/16 for "Vital signs/labs/meds (medications) per order; notify MD (medical doctor) of abnormals."	F 309		

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On 3/10/16 at 1:15 p.m., the Administrator and Director of Nursing (DON) were made aware of the concerns. No further information was provided by the end of the survey.

Steps of administering oral medications: "(i) All tablets or capsules to be given to client at same time may be placed in one medicine cup except for those requiring preadministration assessments. (e.g. pulse rate or blood pressure)." Rationale: "Keeping medications that require preadministration assessments separate from others makes it easier for the nurse to withhold medications as necessary." (853) Perry, Anne and Patricia Potter. Fundamentals of Nursing. 6th ed. St. Louis: Mosby. 2005.

According to Potter & Perry, Fundamentals of Nursing, 7th Edition, 2009, page 386, "Accurate documentation is one of the best defenses for legal claims associated with nursing care, Even though nursing care may have been excellent, in a court of law, 'care not documented is care not provided.' The Nurses Service Organization (medical malpractice, professional liability and risk management company) (2006) has identified common charting mistakes that can result in malpractice: (1) failing to record pertinent health and drug information...."

*Information obtained from https://www.nlm.nih.gov/medlineplus/druginfo/meds/a692051.html

**Information obtained from Geriatric Dosage Handbook, 12th edition, Lexi-Comp, American Pharmacists Association, Page 1442.

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F 309	Continued From page 22 ***Information obtained from http://www.prescriptiondrugs.com/drugs/thera-m-0 ****Information obtained from https://www.nlm.nih.gov/medlineplus/druginfo/meds/a682586.html	F 309		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced	F 329	1. Resident #14 medication orders were reviewed per physician to assure all medication were necessary to maintain health. LPN #6 was given 1:1 counseling on the correct administration of medication and performing necessary tasks such as BP monitoring prior to administration of medications. 2. Audit of EMARS by QA nurse to ensure that all parameters are designated as "tasks". With the electronic health record system, if a "task" is assigned prior to medication administration, the nurse is unable to sign off the medication if the "task" is not complete 3. All LPNs and RNs were educated documenting parameters prior to administrating medications that require a "task" prior to administration.	03/31/2016 03/31/2016 03/31/2016

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F 329	Continued From page 23	F 329	4. QA nurse will do a monthly audit of EMARS and will report results of audits to the QA committee quarterly	04/20/2016

by:
Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to ensure that one of 4 residents in the Medication Administration observation was free of unnecessary medication; Resident #14.

For Resident #14, the facility staff failed to monitor parameters for the administration of Lisinopril in accordance with physician's orders.

The findings include:

Resident #14 was admitted to the facility on 11/6/13 with the diagnoses of but not limited to dementia, blindness, enlarged prostate, dysphagia, and high blood pressure. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 2/15/16. The resident was coded as being cognitively impaired in ability to make daily life decisions. The resident required total care for bathing; extensive assistance for transfers, dressing, eating, and hygiene; and was incontinent of bowel and bladder.

A review of the clinical record revealed an order dated 6/27/14 for "lisinopril* (used to treat high blood pressure) 5 mg (milligrams) daily at 9:00 a.m., hold if the SBP (systolic blood pressure - the top number in a blood pressure reading) is less than 110."

On 3/9/16 at 8:46 a.m., the Medication Administration Observation task was conducted with LPN #6 (Licensed Practical Nurse). She was observed to prepare and administer the following medications for Resident #14:

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lisinopril 5 mg, 1 tab (tablet)
**sodium chloride (used for Prevention of muscle cramps and heat prostration; restoration of sodium ion in hyponatremia) 1 gram tab, gave 2 tabs
***Thera multivitamin 1 tab
****Vitamin B1 (replacement therapy) 100 mg, one tab.

LPN #6 administered the lisinopril 5 mg tab to Resident #14 without taking a blood pressure.

On 3/10/16 at 2:16 p.m., a phone interview was conducted with LPN #6. When asked about the blood pressure, she stated she took the blood pressure at about 7:50 a.m. (approximately 1 hour before administering the lisinopril). When asked where she documented this, she stated on the 24-hour report form. A review of the 24 hour report revealed that there were no notes of any sort, including vital signs, documented next to the name of Resident #14.

A review of the clinical record for February 2016 and March 2016 failed to reveal any evidence of any blood pressures taken except for a monthly blood pressure on 2/1/16, which was 136/48, and was not taken in conjunction with the administration of the lisinopril. Also a nurse's note documented on 3/7/16 a blood pressure of 130/70, which also was not in conjunction with the administration of the lisinopril. No other evidence of blood pressure could be located in the clinical record for February and March 2016.

A review of the care plan for Resident #14 revealed one dated 2/16/16 for "Cardio; Dx (diagnoses) of HTN (high blood pressure)....Receives antihypertensives/cardiac

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meds daily." Interventions included one dated 2/16/16 for "Vital signs/labs (laboratory tests)/meds (medications) per order; notify MD (medical doctor) of abnormals."

A review of the facility policy, "Medication Administration" documented, "20. Medications that requires blood pressure (BP) parameters are charted in the MAR."

On 3/10/16 at 1:15 p.m., the Administrator and Director of Nursing (DON) were made aware of the concerns. No further information was provided by the end of the survey.

Steps of administering oral medications: "(i) All tablets or capsules to be given to client at same time may be placed in one medicine cup except for those requiring preadministration assessments. (e.g. pulse rate or blood pressure)." Rationale: "Keeping medications that require preadministration assessments separate from others makes it easier for the nurse to withhold medications as necessary." (853) Perry, Anne and Patricia Potter. Fundamentals of Nursing. 6th ed. St. Louis: Mosby. 2005.

According to Potter & Perry, Fundamentals of Nursing, 7th Edition, 2009, page 386, "Accurate documentation is one of the best defenses for legal claims associated with nursing care, Even though nursing care may have been excellent, in a court of law, 'care not documented is care not provided.' The Nurses Service Organization (medical malpractice, professional liability and risk management company) (2006) has identified common charting mistakes that can result in malpractice: (1) failing to record pertinent health and drug information...."

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*Information obtained from https://www.nlm.nih.gov/medlineplus/druginfo/meds/a692051.html

**Information obtained from Geriatric Dosage Handbook, 12th edition, Lexi-Comp, American Pharmacists Association, Page 1442.

***Information obtained from http://www.prescriptiondrugs.com/drugs/thera-m-0

****Information obtained from https://www.nlm.nih.gov/medlineplus/druginfo/meds/a682586.html

F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to store and serve food in a sanitary manner.	F 371	1a. Exposed margarine pats were discarded. Margarine purchased in single serve individually wrapped cups. 1b. Bag of hash brown potato patties that was left opened exposing it to air and not dated was thrown away. 1c. Measuring cup was removed from plastic tub labeled thickener. 1d. Scoop that was in the brown sugar with handle touching the sugar was removed, cleaned, and stored outside of food product within the containers.	03/08/2016 03/08/2016 03/08/2016 03/08/2016

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F 371	Continued From page 27 Food was observed uncovered and exposed to air in the freezer and refrigerator. Three bins of bulk items had the scoops/cups stored in the food and dishware was contaminated by a personal cell phone charger. The findings include: Observation was made of the kitchen on 3/8/16 at 12:41 p.m., accompanied by other staff member (OSM) # 4, the dietary manager. An observation of the reach in refrigerator revealed a case of individual margarine patties open and exposed to air. When asked if the food could be stored that way, OSM #4 stated, "They were just in there getting some out." When asked again if margarine patties are to be stored in this manner, OSM # 4 stated, "No." Observation was made of the walk in freezer. A bag of hash brown potato patty was observed with no date when opened and was open and exposed to air. When asked if the bag should be open and exposed to air, OSM # 4, stated, "No." The facility policy, "Storage" documented, "Storage of Perishable Food Items...10. All food items in refrigerators are properly dated, labeled and placed in containers with lids, or are loosely wrapped. 11. All frozen food is dated, labeled and wrapped. Moisture - proof, tight fitting materials are used to prevent freezer burn." A plastic tub labeled "thickener" was observed. A plastic two cup measuring cup was lying on its side inside the tub of thickener. When asked if the cup should be inside the tub of thickener, OSM # 4 stated, "No, that's why there is a hook	F 371	1e. Scoop that was in the chicken breader was removed, cleaned, and stored outside of food product within the container. 1f. Cell phone charger was removed from dietary department. Food Service Manager to discipline employee responsible. 2a. 100% check of reach in refrigerator was conducted by Dietary Manager to make sure no other food products were improperly stored. 2b. 100% check of all foods in the reach in freezer to make sure all items were labeled with date opened and wrapped in moisture proof tight fitting materials to avoid freezer burn by Dietary Manager. 2c. 100% check by Dietary Manager of all thickener containers that have measuring cups as scoops making sure measuring cups are not being used. 2d. 100% check by Dietary manager of all containers and equipment that can be closed that contains food (that is not potentially hazardous) and ensure utensils are properly stored.	03/08/2016 03/08/2016 03/09/2016 03/09/2016 03/09/2016 03/09/2016

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F 371	Continued From page 28 on the front of the container." A plastic tub containing brown sugar was observed. The scoop was sitting in the brown sugar, with the handle touching the sugar. When asked about the scoop, OSM # 4 stated, "She probably used it this morning with breakfast." A plastic tub containing chicken breader (breaded coating for chicken) was observed with the scoop in the mixture, the mixture was observed all over the scoop and handle. The administrative team was made aware of the above concerns on 3/9/16 at 5:35 p.m. Policies were requested on storage of the scoops. On 3/10/16 at 8:00 a.m. a copy of the Commonwealth of Virginia Board of Health Food Regulations was presented as the facilities policy on the scoops in the storage bins. The regulations documented, "In food that is not potentially hazardous with the handles above the top of the food within containers or equipment that can be closed, such as bins of sugar, flour or cinnamon." A rack of clean pudding/dessert cups was noted on the dolly in the kitchen. A flashing light of blue and red on a cord was noted to be sitting in the dishes. When asked what the device was, OSM # 4 stated, "That's a cellphone charger." OSM # 4 pulled the charger out of the wall and handed it to an employee and told them to throw it away. No further comments from OSM # 4 The administrative team was made aware of these concerns on 3/9/16 at 5:35 p.m. A policy	F 371	2e. 100% check of all scoops by Dietary Manager in similar food containers are clean and properly stored 2f. 100% check by Dietary Manager of kitchen for items that are not supposed to be there (like cell phone chargers) or any other personal property that could contaminate clean dishes, food , etc. 3. In-service all of Dietary Personnel by Dietitian, Elizabeth Currin Zumbro on the following: How to store, prepare, distribute and serve food under sanitary conditions. Specifically, how dietary staff failed to store and serve food in a sanitary manner on 03/8/16. Food was observed uncovered and exposed to air in the freezer and refrigerator. Three bins of bulk items had scoops/cups stored in the food product and dish ware was contaminated by a personal cell phone charger. 4.Dietitian will inspect all areas of deficient practice (a-f) during her weekly visits and sign off on form that is listing these areas of deficient practice.	03/09/2016 03/08/2016 03/31/2016 03/31/2016

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F 371	Continued From page 29 on cell phones and storage of clean dishware was requested. The following policy was received. No further polices were received. The facility policy, "Personal Electronic Devices and Cell Phones" documented, "Personal cell phones are not to be used by employees while working. Personal cell phones may be used during break time and meal time, only. Personal cell phones are to be turned off or on the vibrate mode at all times while in the facility." No further information was provided prior to exit.	F 371	cont. of # 4. Dietary Manager or designee will check the areas of deficient practice daily to ensure no more deficient practices are occurring with weekly report to Administrator. Administrator will report findings of Dietary Manager and Dietitian quarterly to Q.A. committee	03/31/2016 04/20/2016
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to ensure timely physician's visits for one of 22 residents in the survey sample; Resident #5. The physician last visited Resident #5 on 12/23/15, and not again as of the day of survey	F 387	1. Resident #5 was seen by physician and orders were re-certified and progress note written on 03/14/2016. 2. 100% o charts were audited per unit manager to ensure 100%compliance of physician visits (recertification) 3. In-serviced unit managers regarding the frequency timeliness of physician visits as required by the Medicare and Medicaid guidelines. 4. QA nurse will audit monthly to assure that visits are done according to Medicare/Medicaid guidelines and will report compliance to the QA committee on a quarterly basis.	03/14/2016 03/14/2016 03/31/2016 04/20/2016

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on 3/9/16, approximately 77 days without a visit.

The findings include:

Resident #5 was admitted to the facility on 7/25/14 with the diagnoses of but not limited to metabolic encephalopathy, coronary artery disease, stroke, atrial fibrillation, diabetes, dysphagia, high blood pressure, and feeding tube.

The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 2/2/16. The resident was coded as being cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for all areas of activities of daily living, and was incontinent of bowel and had an indwelling catheter for bladder.

A review of the clinical record revealed the following physician progress notes: 6/24/15, 8/21/15, 10/23/15, 11/2/15, and 12/23/15. As of the review of this clinical record during survey on 3/9/16, there had been no further physician progress notes since 12/23/15, a period of approximately 77 days.

On 3/10/16 at 8:40 a.m., in an interview with RN #1 (Registered Nurse) the unit manager, she stated that she tracks physician's visits for her unit, and that she had missed ensuring the resident was seen as required.

A review of the facility policy identified only as "Attachment C" documented, "The Qualified Providers of Health Center shall provide the following services as Qualified Provider:.....F.

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F 387	Continued From page 31 Agrees to see residents as needed and to see them no less frequently than every 30 days for the first 90 days after admission and then every 60 days for recertification." On 3/10/16 at 1:15 p.m., the Administrator and Director of Nursing (DON) were made aware of the concerns. No further information was provided by the end of the survey.	F 387		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 431	1. LPN #6 was counseled in regards to medication being left on top of medication cart and having the medication cart in viewing range while administering medication to residents. 03/31/2016 2. In-service all RNs and LPNs in regards to medication administration policy and protocol. In-service all RNs and LPNs to not leave medication on top of cart while administering medications. 03/31/2016 3. QA nurse will perform a medication pass with medication administration nurses on a monthly basis. 03/31/2016 4. Unit Manager will evaluate nurses administering medications and report to the QA committee quarterly. 04/20/2016	

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Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to ensure medications were stored in locked compartments on one of 2 nursing units, the South unit.

On 3/9/16 during the Medication Administration Observation task, the facility staff left medication unsecured and unsupervised on top of the medication cart on the south unit.

The findings include:

On 3/9/16 at 8:46 a.m., the Medication Administration Observation task was conducted with LPN #6 (Licensed Practical Nurse). She was observed to prepare and administer the following medications for Resident #14:
*lisinopril 5 mg, 1 tab (tablet)
**sodium chloride (used for Prevention of muscle cramps and heat prostration; restoration of sodium ion in hyponatremia) 1 gram tab, gave 2 tabs
***Thera multivitamin 1 tab (vitamin replacement therapy)
****Vitamin B1 (replacement therapy) 100 mg, one tab.

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After preparing the above medications, LPN #6 then went into the dining room to administer the medications to Resident #14. While LPN #6 was in the dining room, her cart was left to the side of the doorway to the dining room, out of her sight. LPN #6 left 2 cards of medication on top of the cart, unsecured and unsupervised. Each card contained 14 tabs of *****Cefuroxime 500 mg (an antibiotic) which contained a pharmacy label identifying the medication as belonging to Resident #13. During this time, 2 unidentified residents were observed to pass by the medication cart.

After administering the medications to Resident #14, she returned to the cart. On 3/9/16 at 8:51 a.m., LPN #6 then prepared and administered the following medications for Resident #15:
*^Certavite multivitamin, 1 tab (vitamin replacement therapy)
**^Colace 100 mg tabs, 2 tabs (a stool softener)
***^Ativan 0.5 mg tab, 1 tab (used to treat anxiety)
****^ Metoprolol 50 mg tab, 1 tab (used to treat high blood pressure)
^ Zoloft 50 mg tab, 1 tab. (used to treat depression)

At this time, she took the cards of the Cefuroxime and placed them inside the Narcotic count notebook which was on top of the medication cart, and closed the notebook cover over the medication. However the medication remained unsecured and out of line of sight of LPN #6 as she administered medications to Resident #15 in the dining room.

On 3/9/16 at 8:58 a.m., LPN #6 was then

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observed to prepare and administer the following medications for Resident #21:
Norvasc 5 mg, 1 tab (used to treat high blood pressure)
#* B Complex vitamin, 1 tab (vitamin replacement therapy)
#**Benazapril 40 mg, 1 tab (used to treat high blood pressure)
#***Eliquis 5 mg, 1 tab (used to prevent strokes and blood clots)
#****Letrozole 2.5 mg, 1 tab (used to treat breast cancer)
#*****Vitamin C 65/125 mg (vitamin replacement therapy)

The cards of the Cefuroxime remained inside the Narcotic count notebook which was on top of the medication cart, and the notebook cover was closed over the medication. However the medication remained unsecured and out of line of sight of LPN #6 as she administered medications to Resident #21 in the dining room.

On 3/9/16 at 2:15 p.m., in an interview with LPN #6, she stated the medication was discontinued, but that she should have secured them in the cart.

A review of the facility policy, "Medication Administration" documented, "22. Never leave medication cart open and unattended."

On 3/10/16 at 1:15 p.m., the Administrator and Director of Nursing (DON) were made aware of the concerns. No further information was provided by the end of the survey.

Resident #13 was admitted to the facility on

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12/19/11 with the diagnoses of but not limited to Alzheimer's disease, bronchitis, hip fracture, osteoporosis, edema, hypothyroidism, diabetes, and high blood pressure. The most recent MDS was a quarterly assessment with an ARD of 2/2/16. The resident was coded as being cognitively impaired in ability to make daily life decisions. The resident required total care for bathing; extensive assistance for transfers, dressing, and hygiene; supervision for eating; and was incontinent of bowel and bladder.

Resident #14 was admitted to the facility on 11/6/13 with the diagnoses of but not limited to dementia, blindness, enlarged prostate, dysphagia, and high blood pressure. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 2/15/16. The resident was coded as being cognitively impaired in ability to make daily life decisions. The resident required total care for bathing; extensive assistance for transfers, dressing, eating, and hygiene; and was incontinent of bowel and bladder.

Resident #15 was admitted on 9/20/14 with the diagnoses of but not limited to cholecystectomy, conduct disorder, hip fracture, coronary artery disease, Parkinson's disease, anoxic brain injury, traumatic brain injury, and mini-stroke. The most recent MDS was a quarterly assessment with an ARD of 2/21/16. The resident was coded as being cognitively impaired in ability to make daily life decisions. The resident required total care for bathing, hygiene, and transfers; extensive assistance for dressing and eating; and was incontinent of bowel and bladder.

Resident #21 was admitted to the facility on

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7/7/14 with the diagnoses of but not limited to Alzheimer's disease, osteoporosis, coccyx fracture, high blood pressure, and breast cancer. The most recent MDS was a quarterly assessment with an ARD of 1/14/16. The resident was coded as being cognitively impaired in ability to make daily life decisions. The resident required total care for bathing, hygiene, and toileting; extensive assistance for transfers, dressing, and eating; and was incontinent of bowel and bladder.

*Information obtained from https://www.nlm.nih.gov/medlineplus/druginfo/meds/a692051.html

**Information obtained from Geriatric Dosage Handbook, 12th edition, Lexi-Comp, American Pharmacists Association, Page 1442.

***Information obtained from http://www.prescriptiondrugs.com/drugs/thera-m-0

****Information obtained from https://www.nlm.nih.gov/medlineplus/druginfo/meds/a682586.html

*****Information obtained from https://www.nlm.nih.gov/medlineplus/druginfo/meds/a601206.html

*^ Information obtained from http://www.webmd.com/drugs/2/drug-2141-4249/certa-vite-oral/multivitaminsincludesprenatalvitaminsliquid-oral/details

**^ Information obtained from

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F 431	Continued From page 37 https://www.nlm.nih.gov/medlineplus/druginfo/meds/a601113.html ***^ Information obtained from https://www.nlm.nih.gov/medlineplus/druginfo/meds/a682053.html ****^Information obtained from https://www.nlm.nih.gov/medlineplus/druginfo/meds/a682864.html ^ Information obtained from https://www.nlm.nih.gov/medlineplus/druginfo/meds/a697048.html # Information obtained from https://www.nlm.nih.gov/medlineplus/druginfo/meds/a692044.html #*Information obtained from https://www.nlm.nih.gov/medlineplus/bvitamins.html #**Information obtained from https://www.nlm.nih.gov/medlineplus/druginfo/meds/a692011.html #***Information obtained from https://www.nlm.nih.gov/medlineplus/druginfo/meds/a613032.html #****Information obtained from https://www.nlm.nih.gov/medlineplus/druginfo/meds/a698004.html #*****Information obtained from https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=Vitamin+C	F 431		

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F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

1. 1:1 counseling with LPN #6 regarding how to administer medications in a sanitary manner. — 03/31/2016

2. DON, ADON, and QA nurse will audit medication administration technique of all licensed nurses. — 03/31/2016

3. In-service all LPNs and RNs regarding infection control techniques for medication administration. Review the medication cart setup for medication administration in a sanitary manner. Hand hygiene protocol reviewed with licensed staff. — 03/31/2016

4. QA nurse will review monthly infection control practices and report to the QA committee quarterly. — 04/20/2016

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This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to administer medications in a sanitary manner for 3 of 4 residents in the Medication Administration observation; Resident #14, #15, and #21.

For Resident #14, #15, and #21, the facility staff contaminated the inside of the medication cups prior to preparing medications during the Medication Administration observation on 3/9/16.

The findings include:

On 3/9/16 at 8:46 a.m., the Medication Administration Observation task was conducted with LPN #6 (Licensed Practical Nurse). She was observed to prepare and administer the following medications for Resident #14:
*lisinopril 5 mg, 1 tab
**sodium chloride (used for Prevention of muscle cramps and heat prostration; restoration of sodium ion in hyponatremia) 1 gram tab, gave 2 tabs
***Thera multivitamin 1 tab (vitamin replacement therapy)
****Vitamin B1 (replacement therapy) 100 mg, one tab.

At the beginning of preparation, when obtaining a medication cup to put the medications in, she inserted a finger down into the medication cup, contaminating the inside of the cup where the medications would be placed. She then prepared and administered the medications to Resident

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F 441	Continued From page 40	F 441		

#14.

On 3/9/16 at 8:51 a.m., LPN #6 then prepared and administered the following medications for Resident #15:
*^Certavite multivitamin, 1 tab (vitamin replacement therapy)
**^Colace 100 mg tabs, 2 tabs (a stool softener)
***^Ativan 0.5 mg tab, 1 tab (used to treat anxiety)
*****^ Metoprolol 50 mg tab, 1 tab (used to treat high blood pressure)
^ Zoloft 50 mg tab, 1 tab. (used to treat depression)

At the beginning of preparation, when obtaining a medication cup to put the medications in, she inserted a finger down into the medication cup, contaminating the inside of the cup where the medications would be placed. She then prepared and administered the medications to Resident #15.

On 3/9/16 at 8:58 a.m., LPN #6 was then observed to prepare and administer the following medications for Resident #21:
Norvasc 5 mg, 1 tab (used to treat high blood pressure)
#* B Complex vitamin, 1 tab (vitamin replacement therapy)
#**Benazapril 40 mg, 1 tab (used to treat high blood pressure)
#***Eliquis 5 mg, 1 tab (used to prevent strokes and blood clots)
#****Letrozole 2.5 mg, 1 tab (used to treat breast cancer)
#*****Vitamin C 65/125 mg (vitamin replacement

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therapy)

At the beginning of preparation, when obtaining a medication cup to put the medications in, she inserted a finger down into the medication cup, contaminating the inside of the cup where the medications would be placed. She then prepared and administered the medications to Resident #21.

On 3/9/16 at 2:15 p.m., in an interview with LPN #6, she stated that she was not aware she did that but knew better.

A review of the facility policy, "Protocol for Medication Administration" documented: "5. The residents' medications must be handled in a way that meets the standards of infection control...."

On 3/10/16 at 1:15 p.m., the Administrator and Director of Nursing (DON) were made aware of the concerns. No further information was provided by the end of the survey.

In "Fundamentals of Nursing" 7th edition, 2009: Patricia A. Potter and Anne Griffin Perry: Mosby, Inc; Page 655. "The nurse follows certain principles and procedures, including standard precautions, to prevent and control infection and its spread. During daily routine care the nurse uses basic medical aseptic techniques to break the infection chain. A major component of client and worker protection is hand hygiene. Contaminated hands of health care workers are a primary source of infection transmission in health care settings."

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Resident #14 was admitted to the facility on 11/6/13 with the diagnoses of but not limited to dementia, blindness, enlarged prostate, dysphagia, and high blood pressure. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 2/15/16. The resident was coded as being cognitively impaired in ability to make daily life decisions. The resident required total care for bathing; extensive assistance for transfers, dressing, eating, and hygiene; and was incontinent of bowel and bladder.

Resident #15 was admitted on 9/20/14 with the diagnoses of but not limited to cholecystectomy, conduct disorder, hip fracture, coronary artery disease, Parkinson's disease, anoxic brain injury, traumatic brain injury, and mini-stroke. The most recent MDS was a quarterly assessment with an ARD of 2/21/16. The resident was coded as being cognitively impaired in ability to make daily life decisions. The resident required total care for bathing, hygiene, and transfers; extensive assistance for dressing and eating; and was incontinent of bowel and bladder.

Resident #21 was admitted to the facility on 7/7/14 with the diagnoses of but not limited to Alzheimer's disease, osteoporosis, coccyx fracture, high blood pressure, and breast cancer. The most recent MDS was a quarterly assessment with an ARD of 1/14/16. The resident was coded as being cognitively impaired in ability to make daily life decisions. The resident required total care for bathing, hygiene, and toileting; extensive assistance for transfers, dressing, and eating; and was incontinent of bowel and bladder.

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References:

*Information obtained from https://www.nlm.nih.gov/medlineplus/druginfo/meds/a692051.html

**Information obtained from Geriatric Dosage Handbook, 12th edition, Lexi-Comp, American Pharmacists Association, Page 1442.

***Information obtained from http://www.prescriptiondrugs.com/drugs/thera-m-0

****Information obtained from https://www.nlm.nih.gov/medlineplus/druginfo/meds/a682586.html

*^ Information obtained from http://www.webmd.com/drugs/2/drug-2141-4249/certa-vite-oral/multivitaminsincludesprenatalvitaminsliquid-oral/details

**^ Information obtained from https://www.nlm.nih.gov/medlineplus/druginfo/meds/a601113.html

***^ Information obtained from https://www.nlm.nih.gov/medlineplus/druginfo/meds/a682053.html

****^Information obtained from https://www.nlm.nih.gov/medlineplus/druginfo/meds/a682864.html

^ Information obtained from https://www.nlm.nih.gov/medlineplus/druginfo/meds/a697048.html

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F 441	Continued From page 44 # Information obtained from https://www.nlm.nih.gov/medlineplus/druginfo/meds/a692044.html #*Information obtained from https://www.nlm.nih.gov/medlineplus/bvitamins.html #**Information obtained from https://www.nlm.nih.gov/medlineplus/druginfo/meds/a692011.html #***Information obtained from https://www.nlm.nih.gov/medlineplus/druginfo/meds/a613032.html #****Information obtained from https://www.nlm.nih.gov/medlineplus/druginfo/meds/a698004.html #*****Information obtained from https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=Vitamin+C	F 441		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that facility staff failed to obtain a physician ordered laboratory test for one of 22 residents in the	F 502	1. 1:1 counseling with RN#3 regarding labs and updating new orders per MD. Resident #1's orders were reviewed and labwork was obtained per physicians order. 2. RN#3 will audit all labs and ensure that they have been completed in a timely manner. 3. A tracking log will be provided per Labcorp and reviewed monthly by unit managers	03/28/2016 03/28/2016 03/28/2016

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F 502	Continued From page 45 survey sample; Resident #1. Facility staff failed to obtain a CBC (complete blood count)* and CMP (comprehensive metabolic panel)** (laboratory tests) that were ordered by the physician on 11/18/15. The findings include: Resident #1 was admitted to the facility on 8/27/2015 and readmitted on 11/18/2015 with diagnoses that included but were not limited to acute osteomyelitis of the sacral wound, depressive episodes, a-fibrillation, anxiety disorder, and spinal stenosis***. Resident #1's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 3/3/16. Resident #1 was coded as being cognitively intact in the ability to make daily life decisions scoring 15 out of 15 on the BIMS (brief interview for mental status). Resident #1 was coded as requiring extensive assistance from staff with transfers, dressing, toileting, and personal hygiene; independent with meals, and total dependence on staff with bathing. Review of Resident #1's clinical record revealed that Resident #1 arrived back from the hospital to the facility on 11/18/2015. Further review of the clinical record revealed an order dated 11/18/15 that documented the following: "CBC w/diff (with differential); CMP Frequency: Once between the 1st -31st of Feb, May, Aug, Nov..." Review of the clinical record revealed no evidence of a CBC w/diff and CMP being drawn for February 2016.	F 502	4.Unit Managers will report tracking log results to the QA committee quarterly.	04/20/2016

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On 3/10/16 at 10:00 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that Resident #1 went out to the hospital in November and prior to going out to the hospital; she was on a different laboratory schedule. LPN #1 stated that when Resident #1 came back to the facility on 11/18/15, her lab schedule was changed to every Feb, May, Aug and November. LPN #1 stated, "I think (name of lab nurse) must of missed the new schedule and thought she was still on the old lab schedule. The February lab was missed. (Name of lab nurse) has an index card system that is categorized by month and lists residents and the type of lab they need for that month."

On 3/10/16 at 11:40 a.m., an interview was conducted with RN (registered nurse) #3, the laboratory nurse. When asked the process of obtaining routine orders she stated, "I have a box with cards that are rotated out each month. When a resident gets an order for routine labs, I put their name on the card for that month so it is not missed." When asked if she knew what happened with Resident #1's routine CBC and CMP she stated, "For whatever reason I kept her on her old laboratory schedule from when she was originally admitted to the facility. I missed her February lab. I really don't have an excuse for that."

On 3/10/16 at approximately 2:00 p.m., administration was made aware of the above findings. No further information was presented prior to exit.

Facility policy titled, "Laboratory Order Sheet" did not address routine labs.

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According to Fundamentals of Nursing, 5th Edition, Lippincott Williams & Wilkins, 2007. Page 165, Laboratory tests are always interpreted in relation to the client's underlying health problems and treatment modalities. These results can also identify actual or potential health problems....Sometimes, laboratory tests and diagnostic procedures are used to judge the effectiveness of nursing interventions or medical treatment."

*A complete blood count (CBC) test measures the following: The number of red blood cells (RBC count), the number of white blood cells (WBC count); the total amount of hemoglobin in the blood; the fraction of the blood composed of red blood cells (hematocrit). <http://www.nlm.nih.gov/medlineplus/ency/article/003644.htm>

**A comprehensive metabolic panel (CMP) is a group of blood tests. They provide an overall picture of your body's chemical balance and metabolism. Metabolism refers to all the physical and chemical processes in the body that use energy. <http://search.nih.gov/search?utf8=%E2%9C%93&affiliate=nih&query=CMP&commit.x=26&commit.y=3>

***Spinal Stenosis-"Your spine, or backbone, protects your spinal cord and allows you to stand and bend. Spinal stenosis causes narrowing in your spine. The narrowing puts pressure on your nerves and spinal cord and can cause pain." This information was obtained from https://www.nlm.nih.gov/medlineplus/spinalstenos

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F 502	Continued From page 48 is.html.	F 502		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	F 514	1. Resident #18 is no longer a resident at the facility; left AMA on 10/25/2015. LPN #7 is no longer employed by the facility.	03/31/2016
			2. QA nurse has audited all EMARs for documentation completion.	03/31/2016
			3. In-service all licensed nurses on medication administration protocols and the importance of documenting the administration of medications on the EMAR.	03/31/2016
			4. QA nurse will do monthly medication pass and audit of EMARS and report to QA committee quarterly	04/20/2016

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to ensure a complete and accurate clinical record for one of 22 residents in the survey sample; Resident #18.

For Resident #18, the clinical record contained conflicting information on the administration of medication. A nurse's note documented the administration of a pain medication but the MAR did not.

The findings include:

Resident #18 was admitted on 10/24/15 and left

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the facility AMA (against medical advice) on 10/25/15. Resident #18 was admitted with the diagnoses of but not limited to hernia repair, diabetes, fibromyalgia, and degenerative disc disease. An MDS (Minimum Data Set) had not yet been completed. According to nurse's notes and admission assessments dated 10/24/15, the resident was alert and oriented to person, place, and time; was independently ambulatory, was independent in activities of daily living, and was continent of bowel and bladder.

During the investigation of a complaint allegation about the availability and administration of pain medication for Resident #18, a review of the clinical record revealed the following:

New admission medication orders which included: Lortab* (used to relieve moderate to severe pain) 5-325 mg (milligrams) every 4 hours PRN (as needed) and STAT (immediately).

A review of the pharmacy delivery manifest revealed the Lortab was delivered on 10/24/15 at 10:01 p.m. A review of the MAR (Medication Administration Record) failed to reveal evidence that the Lortab was administered, however a nurse's note dated 10/24/15 at 10:36 p.m. documented, "Lortab 5-325 given for c/o (complaints of) back pain."

On 3/10/16 at 1:41 p.m., in a phone interview with LPN #8 (Licensed Practical Nurse), who no longer worked at the facility, she stated that LPN #7 administered meds to the resident and should have signed them out on the MAR.

Attempts were made to contact LPN #7, who no longer worked at the facility, on 3/10/16 at 10:23

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F 514	Continued From page 50	F 514		

a.m., 11:48 a.m., and 11:56 a.m., as this was also part of a complaint investigation.

A review of the facility policy "Medication Administration" documented, "8. Every administration shall be recorded immediately on the resident's chart and initialed by the person administering it."

On 3/10/16 at 1:15 p.m., the Administrator and Director of Nursing (DON) were made aware of the concerns. No further information was provided by the end of the survey.

According to Fundamentals of Nursing, Sixth edition, 2007; by Perry and Potter, page 843 reads "After the nurse administers the medication, the medication administration record (MAR) is completed per agency policy to verify that the medications was given as ordered."

According to Potter & Perry, Fundamentals of Nursing, 7th Edition, 2009, page 386, "Accurate documentation is one of the best defenses for legal claims associated with nursing care, Even though nursing care may have been excellent, in a court of law, 'care not documented is care not provided.' The Nurses Service Organization (medical malpractice, professional liability and risk management company) (2006) has identified common charting mistakes that can result in malpractice: (1) failing to record pertinent health and drug information...."

*Information obtained from https://www.nlm.nih.gov/medlineplus/druginfo/meds/a601006.html

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495358	A. BUILDING _____ B. WING _____	C 03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMELIA NURSING CENTER	8830 VIRGINIA STREET AMELIA, VA 23002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 51	F 514		

COMPLAINT DEFICIENCY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495358	A. BUILDING _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMELIA NURSING CENTER	8830 VIRGINIA STREET AMELIA, VA 23002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 000	Initial Comments	F 000		

An unannounced biennial State Licensure Inspection was conducted 03/08/16 through 03/10/16. Corrections are required to be in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow.

The census in this 100 certified bed facility was 88 at the time of the survey. The survey sample consisted of 16 current resident reviews (Residents # 1 through # 15 and # 21) and six closed record reviews (Residents # 16 through # 20 and #22).

F 001 Non Compliance — F 001

The facility was out of compliance with the following state licensure requirements:

This RULE: is not met as evidenced by:
12 VAC 5 - 371 - 340 A cross references to Federal Tag F 371

12VAC5-371-140. Policies and procedures.
Cross Reference to F329, F387, F441, F514

12VAC5-371-180. Infection control.
Cross reference to F441

12VAC5-371-200. Director of nursing.
Cross Reference to F281

12VAC5-371-220. Nursing services.
Cross Reference to F309, F329

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495358	A. BUILDING _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMELIA NURSING CENTER	8830 VIRGINIA STREET AMELIA, VA 23002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 001	Continued From Page 1	F 001		

12VAC5-371-240. Physician services.
Cross Reference to F329, F387

12VAC5-371-250. Resident assessment and care planning.
Cross Reference to F309, F329

12VAC5-371-300. Pharmaceutical services.
Cross Reference to F329

12VAC5-371-360. Clinical records.
Cross Reference to F514
12VAC5-371-150 cross reference to F164

12VAC5-371-150 cross reference to F225

12VAC5-371-220 cross reference to F280

12VAC5-371-240E cross reference to F502

COMMONWEALTH of VIRGINIA

Virginia Department of Fire Programs

Melvin D. Carter
EXECUTIVE DIRECTOR

State Fire Marshal's Office
Central Region
1005 Technology Park Drive
Glen Allen, VA 23059-4500
Phone: 804/ 371-0220
Fax: 804/ 371-3367

Kathaleen Creegan-Tedeschi, Director
Office of Licensure/Certification
Division of Long Term Care
Virginia Department of Health
9960 Mayland Drive
Perimeter Center Suite 401
Henrico, VA 23233

RE: Amelia Nursing Center
8830 Virginia Street
Amelia, VA 23002
File Number: **C-0140-001**
CMS Certification Number: **495358**
Event ID Number: **PCDJ21**

The attached report is forwarded to you with the following comments:

I. SURVEY [X]

[X] Recommend certification based on compliance with Life Safety Code.
[ ] Recommend certification based on acceptable POC.
[ ] Recommend certification based on acceptable POC and a scope and severity of C or less with no revisit required.
[ ] Recommend certification based on compliance with LSC by requested continuous waiver.
[ ] Recommend certification based on compliance with LSC by requested Time Limited waiver.
[ ] Recommend certification based on satisfactory results from application of the FSES.
[ ] Do not recommend certification.

II. POST SURVEY [ ]

[ ] All deficiencies corrected:

[ ] All deficiencies not corrected:

- [ ] Recommend certification based on acceptable POC
- [ ] Recommend certification based on acceptable POC and a scope and severity of C or less with no revisit required.
- [ ] Recommend certification based on approved or requested continuous waiver.
- [ ] Recommend certification based on approved or requested Time Limited waiver.
- [ ] Do not recommend certification.

If you have any questions or if we may be of further assistance, please contact me at 804-371-0220

Sincerely,

Ronald C Reynolds - RCR

Ronald C. Reynolds
Deputy State Fire Marshal

Survey Date: 03/23/2016 SOD Sent: N/A POC Rec'd: N/A POC to HQ: 03/29/2016
Highest Scope/Severity: N/A (N/A is one option)

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X t) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
	495358	A. BUILOING **01 - MAIN BUILDING 01** B. WING _____	**03/23/2016**

NAME OF PROVIOER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COOE
AMELIA NURSING CENTER	**8830 VIRGINIA STREET** **AMELIA, VA 23002**

(X4) IO PREFIX TAG	SUMMARY STATEMENT OF OEFICIENCIES (EACH OEFICIENCY MUST BE PRECEOEO BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO BE CROSS-REFERENCEO TO THE APPROPRIATE OEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Description of structure: This facility is a sigle-story Type V(000) skilled nursing facility. Sprinkler status: Fully sprinkled in accordance with NFPA-13 An unannounced routine recertification life safety code survey was conducted on 03/23/2016 in accordance with 42 Code of Federal Regulation, Part 483: Requirements for Long Term Care Facilities. The facility was surveyed for compliance using the LSC 2000 Existing regulations. The facility was in compliance with the Requirements for Participation in Medicare and Medicaid.	K 000		

LABORATORY OIRECTOR'S OR PROVIOER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable t4 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.